PEDIATRIC INSTITUTE FOR EPILEPSY AND NEUROLOGICAL DISORDERS

Rashmi Gupta, M.D.
Pediatric Neurologist

29592 Northwestern Hwy.
Southfield, Michigan 48034

Tel: (248) 354-0967
Fax: (248) 354-6614

AUTHORIZATION FOR MEDICAL TREATMENT

I hereby authorize Rashmi Gupta, M.D. of Pediatric Institute for Epilepsy and Neurological Disorders, to perform and oversee all medical treatment and testing she deems necessary to diagnose and treat:

_____ _____
(Patient Name) (Patient Date of Birth)

_____ _____ _____
Printed name of Parent or Legal Guardian Signature of Parent or Legal Guardian* Date

***IF SIGNED BY A LEGAL GUARDIAN, PLEASE ATTACH A COPY OF THE LETTERS OF GUARDIANSHIP TO THIS FORM.**

ASSIGNMENT AND RELEASE

I authorize use of this form on all my insurance submissions.

I authorize release of all information to all of my Insurance Companies, which may require medical reports/tests including diagnosis to be attached to claims submitted to the insurance companies.

I am responsible to report any medical insurance changes and to provide secondary insurance information at the time of service.

I authorize my doctor/medical biller to act as an agent in helping me to obtain payment from my insurance companies.

I understand that I am financially responsible for all charges whether or not paid by my insurance company or card member.

I authorize payment direct to my doctor.

I permit a copy of this authorization to be used in place of the original.

I understand Rashmi Gupta, M.D. and staff of Pediatric Institute for Epilepsy and Neurological Disorders is complying with the Portability and Accountability Act (HIPAA).

I authorize the use of this signature on all insurance submission.

Signature: _____ Date: _____
(Patient, Parent or Legal Guardian)

Witness: _____